North Shore LIJ Medical Group

HOFSTRA NORTH SHORE-LIJ SCHOOL of MEDICINE

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April 3, 2015

Paul Lombardi, M.D.
4207 30th Avenue
Astoria, NY 11103

RE: ERIC SALDARRIAGA
DOB: 10/24/1973
FOLLOW UP: 4/3/2015

Dear Dr. Lombardi:

I had the pleasure today of seeing Mr. Saldarriaga in the office for follow up of his blood pressure. Briefly, he is a 41-year-old man with a history of hypertension, hyperlipidemia, sleep apnea on CPAP, obesity, family history of cardiomyopathy, diverticulosis, GERD, SVT status post ablation in 2005, history of AVMs of the brain with a cerebral hemorrhage in the past, non-obstructive carotid artery stenosis on the right, and anxiety, who presents today for follow up of his blood pressure. He continues to experience increased stress, given the legal issues that he is currently undergoing. He denies any chest pain, however, he does experience dyspnea with exertion. He does mention feeling palpitations that are particularly exacerbated with stress and anxiety.

Past medical history: Hypertension, SVT status post ablation, hyperlipidemia, sleep apnea on CPAP, diverticulosis, GERD, AVMs of the brain with cerebral hemorrhage in the past, neuropathy, and nonobstructive carotid artery disease.

Allergies: He is allergic to penicillin.

Medications: Aspirin 81 mg daily, Cardizem CD 240 mg daily, losartan 100 mg daily, hydrochlorothiazide 12.5 mg (he has been taking daily for the last week), Clarinex 5 mg daily, Lipitor 40 mg daily, Neurontin as needed, Nexium as needed, Xanax, and Lexapro 10 mg daily.

Review of systems: Palpitations. Increased stress and anxiety. All other systems are negative.

Electrocardiogram performed today in the office revealed sinus rhythm with sinus arrhythmia at 65 beats per minute.

Re: **Eric Saldarriaga**
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Physical examination: His blood pressure was 140/90 on the right with a pulse of 72 per minute, respiratory rate of 10 per minute, and weight of 251 pounds with shoes on. Head examination revealed intact extraocular muscles, anicteric sclerae, and no pale conjunctivae. His neck was supple without JVD and no carotid bruits being auscultated. He had no palpable cervical lymphadenopathy and no lower extremity edema. His lungs were clear to auscultation bilaterally with good effort and no wheezing, rales, or rhonchi. Cardiovascular examination revealed the presence of S1 and S2 with a regular rate and rhythm and no murmurs were appreciated. His abdomen was soft and nontender with bowel sounds present and no obvious hepatomegaly, however, this was limited secondary to his body habitus. He had an appropriate mood and affect. He had no rashes or visible ulcers.

Carotid Dopplers performed on December 8, 2014 revealed minimal plaque bilaterally with no significant obstruction. Echocardiogram performed on February 25, 2015 revealed grossly normal left ventricular systolic function with an EF of 65%. Cardiac CT performed on March 12, 2014 revealed a calcium score of 0 with a short segment of an intramyocardial bridge of the mid LAD without significant associated luminal narrowing. Holter monitor performed on February 25, 2015 revealed episodes of sinus tachycardia that were correlated with a stressful situation that he had been encountering.

IMPRESSION: Mr. Saldarriaga is a 41-year-old man with a history of hypertension, hyperlipidemia, sleep apnea, obesity, family history of cardiomyopathy, diverticulosis, GERD, SVT status post ablation in 2005, history of AVMs of the brain with resulting cerebral hemorrhage in the past, nonobstructive carotid artery stenosis, and anxiety who presents today for follow up of his blood pressure.

PLAN:

1. His blood pressure is again elevated which I feel is multifactorial. He has increased stress and anxiety which I feel is contributing to his elevated blood pressure, however, it appears that this is being exacerbated by the current legal issues that he is undergoing. He is also the primary caregiver of his elderly grandmother who has not been taking her antihypertensives. It is my concern that given this continued stress and anxiety that his blood pressure will continue to be elevated despite changing medicines and thus I explained to him the importance of stress management. I also expressed my concerns given his history of AVMs with cerebral hemorrhage in the past now in the setting of elevated blood pressure. He will continue on Cardizem CD 240 mg daily, losartan 100 mg daily and hydrochlorothiazide 12.5 mg daily. I have also explained to him the importance of diet modification as he has gained approximately 6 pounds in about six weeks.
2. He will continue on Lipitor 40 mg daily and I have asked him to follow up with you for a fasting lipid profile and he will continue on Lipitor 40 mg daily. He should have a repeat lipid profile at the time of his next visit as his previous LDL had been trending up. I explained to him the importance of diet modification as well as exercise which he has not been doing given the legal proceedings that he has been undergoing recently.

Re: **Eric Saldarriaga**
DOB: 10/24/1973

3. He has not had any episodes of chest pain recently; however, we have once again discussed the possibilities of chest pain in the setting of his myocardial bridge.
4. He had a Holter monitor that was performed in February 2015 given palpitations that revealed episodes of sinus tachycardia that correlated with a stressful situation that he was facing at that time. I do not feel that a repeat Holter monitor is necessary at this time as I feel that his tachycardia is secondary to anxiety. I again stressed the importance of stress management which I understand is difficult at this time. If he continues to experience palpitations we may need to consider an Event monitor given his history of SVT.
5. He will follow up with me in approximately six weeks for repeat blood pressure check and also to check his cholesterol.
6. I have reinforced the importance of stress management in the setting of elevated blood pressure. He may require to follow up with either you or myself more frequently given his upcoming legal proceedings for follow up of his blood pressure.

Thank you for allowing me to share in the care of this gentleman. Please feel free to contact me should you have any questions.

Sincerely,

Christos Vavasis, M.D. F.A.C.C.

Detailed Assessment of Posttraumatic Stress™

DAPS™ - Interpretive Report

Developed By

John Briere, PhD and PAR Staff

Client Information

Client Name :	Eric Saldarriaga
Client ID :	ES
Test Date :	03/04/2015
Gender :	Male
Birthdate :	10/24/1973
Age :	41

The Detailed Assessment of Posttraumatic Stress (DAPS) provides detailed information about an individual's symptomatic responses to a specific traumatic event. This includes feelings and thoughts that occurred during or soon after the event, as well as later posttraumatic symptoms involving intrusive reliving of the event, avoidance, and autonomic hyperarousal. Posttraumatic dissociation, suicidality, and substance abuse are also evaluated by the DAPS. This information can yield, among other things, a diagnosis of potential posttraumatic stress disorder (PTSD) or acute stress disorder (ASD), as well as information about the severity of the individual's posttraumatic symptoms. The DAPS also may identify individuals at risk for self-destructiveness and serious substance abuse. However, the results of a DAPS administration should always be integrated with a diagnostic interview and whatever other psychometric testing may be required. A diagnosis of ASD or PTSD should not be made on the basis of any single psychological test, including the DAPS.

PAR Psychological Assessment Resources, Inc. / 16204 North Florida Ave. / Lutz, FL 33549 / 1.800.331.8378 / www.parinc.com

Version: 1.01 (2.00.019)

T scores are used in the DAPS to interpret the respondent's level of trauma symptoms as reported on the DAPS answer sheet. These scores are linear transformations of the raw scale scores (M = 50, SD = 10). *T* scores in this report provide information about an individual's scores relative to the scores of individuals in the DAPS standardization sample, a group of 406 trauma-exposed men and women from the general population.

In the process of interpreting DAPS scores, a review of individual items within each scale can yield useful information regarding the specific nature of the respondent's score on that scale. In addition, scores on the individual items of the Trauma Specification section (Part 1) of the DAPS may provide important information about the nature and extent of the individual's traumatic experience(s) (e.g., shame or horror experienced at the time of the trauma). Placing too much interpretive significance on individual items of clinical scales, however, is not recommended due to the lower reliability of individual items relative to the scales and indexes.

Caveats

The DAPS™-Interpretive Report for Windows® provides computer-generated narrative statements that are based on the scoring guidelines and interpretive strategies and principles delineated in the *Detailed Assessment of Posttraumatic Stress Professional Manual*. The interpretive information contained in this report should be viewed as only one source of hypotheses about the individual being evaluated. No decisions should be based solely on the information contained in this report. This material should be integrated with all other sources of information in reaching professional decisions about the individual.

The normative data contained in this report were collected using the standard 104-item paper and pencil version of the DAPS (i.e., not the computer-administered version available in the DAPS-IR computer program). To date, no data have been gathered to demonstrate equivalence between the computerized administration of the DAPS and the paper and pencil version. For this reason, normative scores from the computerized version must be interpreted cautiously. To further estimate the potential effects of a computerized administration of the DAPS on the obtained scale scores, users of the DAPS-IR should be familiar with the original version of the test.

This report is confidential and intended for use by qualified professionals only.

DAPS Score Summary Tables

Validity Scales

Scale	Raw score	T score
Negative Bias *(NB)*	8	46
Positive Bias *(PB)*	0	28

Trauma Specification Scales

Index Trauma	Description
11	Respondent reports: "Our computers were siezed by the FBI with all my personal and professional data. If I am charged with a felony I will lose my license and not be able to continue to support my family."

Scale	Raw score	T score
Relative Trauma Exposure *(RTE)*	2	46
Peritraumatic Distress *(PDST)*	31	73
Peritraumatic Dissociation *(PDIS)*	20	75

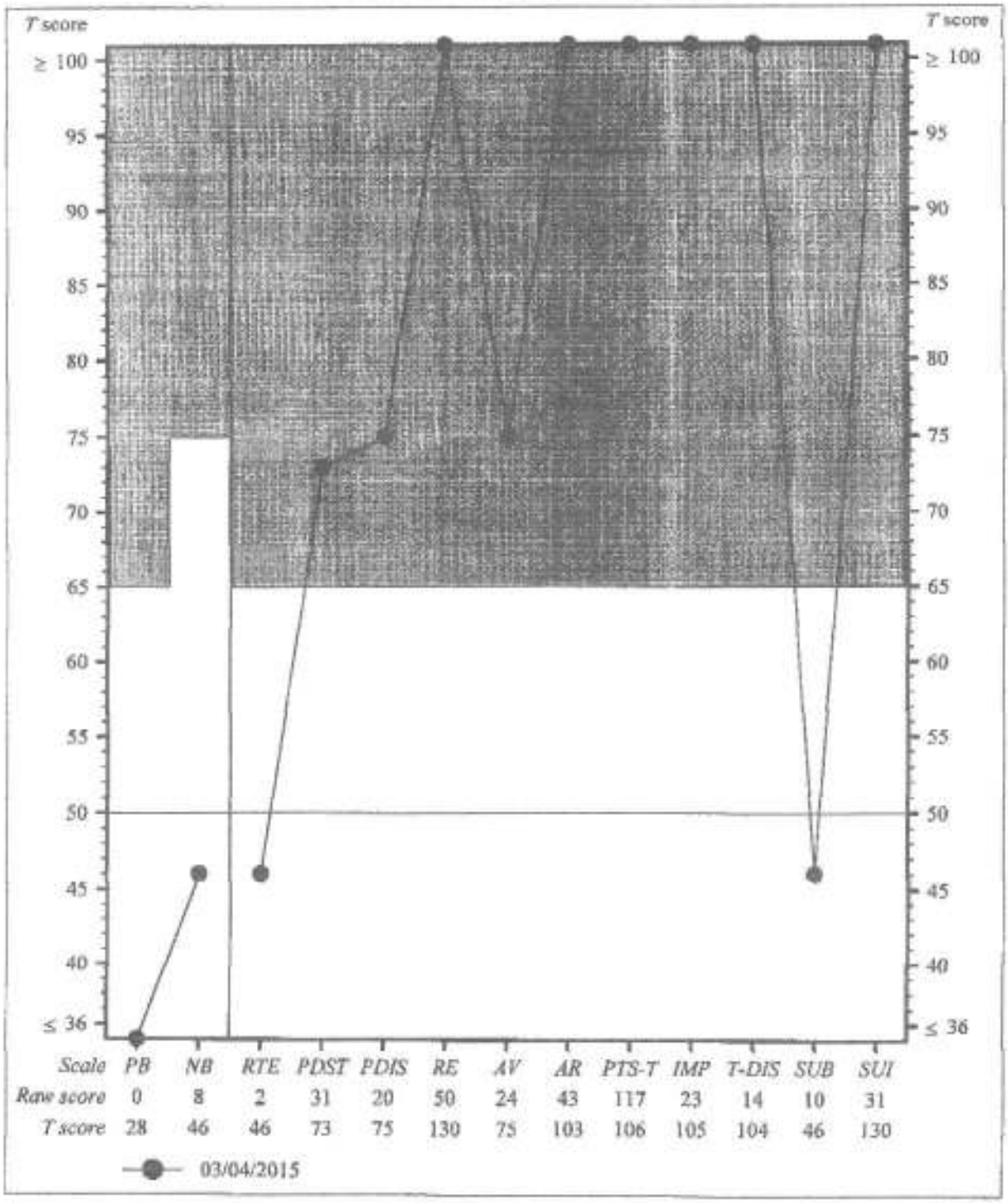
Clinical Scales

Scale	Raw score	T score
Reexperiencing *(RE)*	50	130
Avoidance *(AV)*	24	75
Effortful Avoidance *(AV-E)**	12	84
Numbing *(AV-N)**	5	51
Hyperarousal *(AR)*	43	103
Posttraumatic Stress - Total *(PTS-T)*	117	106
Posttraumatic Impairment *(IMP)*	23	105
Trauma-Specific Dissociation *(T-DIS)*	14	104
Substance Abuse *(SUB)*	10	46
Suicidality *(SUI)*	31	130

** Generated by Scoring Program only.*

A table of the individual's item raw scores for all of the DAPS items can be found at the end of this report.

Profile of DAPS™ *T* Scores



Note Male-specific norms have been used to generate this profile. For additional information about the standardization sample and the normative data, refer to chapter 4 and Appendixes A and B, respectively, in the DAPS Professional Manual.

Validity

In order to interpret the respondent's DAPS scores, he must have endorsed a sufficient number of items overall, and his scores on the two DAPS validity scales, Positive Bias *(PB)* and Negative Bias *(NB)*, should be in the acceptable range.

There are no missing item responses in the protocol.

Overall, the respondent's item endorsements do not appear to be overly positive. He does not appear to deny more normal problems or difficulties than others with a trauma history readily endorse. He did not deny any of the *PB* scale items (i.e., no items were endorsed as "Never").

Overall, the respondent's item endorsements do not suggest that he is attempting to portray himself in an especially negative or pathological manner. He did not endorse any *NB* scale items at a significant level (i.e., at least "Once or twice" during the last month).

Trauma Specification

Index Trauma

The index trauma is the trauma that the respondent (or his therapist) selected as the most upsetting or most clinically important at this point in time. All subsequent responses on the DAPS are given with reference to this index trauma.

The respondent indicated on the DAPS that his index trauma is having experienced an unspecified traumatic event. The respondent described this trauma in the following manner: "Our computers were siezed by the FBI with all my personal and professional data. If I am charged with a felony I will lose my license and not be able to continue to support my family." The traumatic experience occurred a year ago or longer.

Trauma History

Although the respondent specified an index trauma on which to base his item endorsements on the DAPS, in many cases an individual's response to a given traumatic event is affected by other traumas occurring either before or after the index event. These additional traumas also may produce significant symptomatology, including the possibility of separate PTSD and/or ASD diagnoses associated with these other traumas. The respondent's endorsement for each of the 13 potential traumas listed in the DAPS Item Booklet (including the index trauma) are presented below.

Potential trauma exposures	Item response
1. An accident or crash involving a car, motorcycle, plane, boat, or other vehicle.	No
2. A hurricane, tornado, flood, earthquake, explosion, or fire.	No
3. An accident at work or at home.	Yes
4. Someone hitting, choking, or beating him (including someone he lived with or was married to) at any time in his life, including childhood.	No
5. Someone threatening to injure him or do something sexual to him against his will, *although they didn't actually do anything to him.*	No
6. Someone shooting or stabbing him, or trying to shoot or stab him.	No
7. Being in a war.	No

Potential trauma exposures	Item response
8. Being held-up, robbed, or mugged.	No
9. Someone doing something sexual to him against his will (for example, rape, sexual assault, or unwanted sexual contact), or making him do something sexual.	No
10. Someone doing something sexual to him or making him do something sexual *before he was 16 years old* (sexual abuse).	No
11. Some other experience that caused him to be seriously hurt or to be afraid that he might be seriously hurt or killed.	Yes
12. Seeing someone else get seriously hurt or killed.	No
13. An adult hit or beat him or in some other way physically hurt him enough to cause scratches, bruises, cuts, or some other injury *before he was 16 years old* (physical abuse)	No

As indicated above, he endorsed at least one additional type of trauma exposure. The clinician should determine (a) if the additional trauma or traumas listed above represent more than one event, (b) if the additional trauma or traumas are clinically significant, and (c) if they require additional assessment – either with another DAPS administration or by clinical interview. In addition, as a general practice, the assessor should consider the possibility of compounded responses when the respondent reports more than one trauma. For example, the client may attribute symptoms to one traumatic event that are at least partially due to the additional influence of other traumatic events, or, in some relatively rare cases, may even confuse the effects of one trauma with the effects of another trauma.

His Relative Trauma Exposure *(RTE) T* score is 46, indicating that the total number of trauma types to which he has been exposed is about average among people who report a trauma history. However, this does not mean that he has not had numerous trauma exposures within a given trauma type.

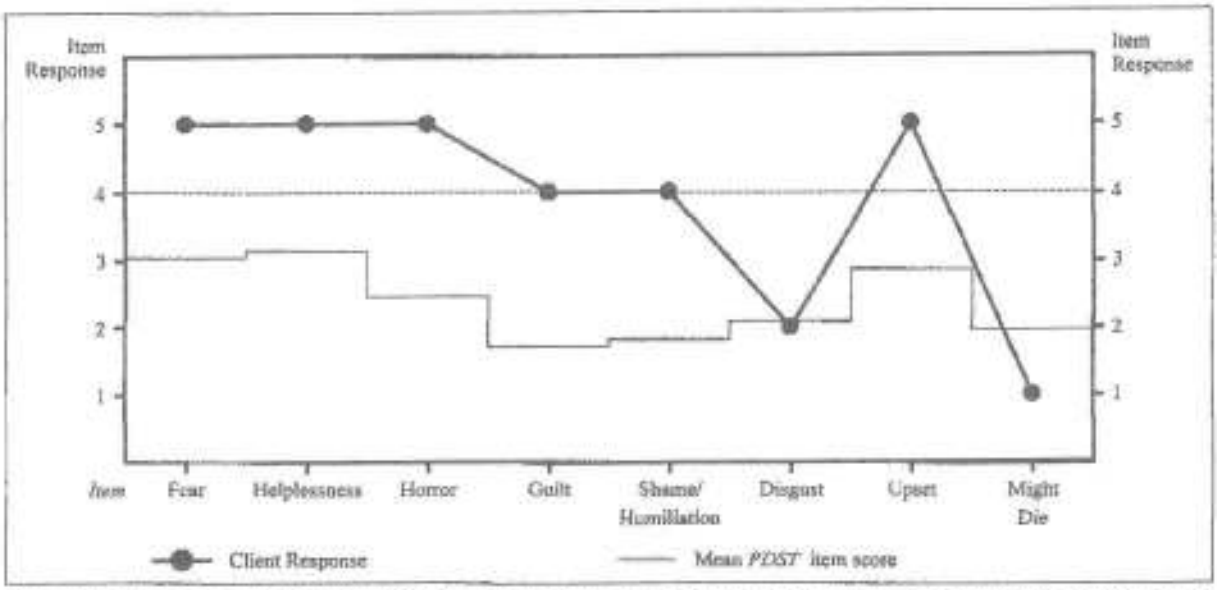
Peritraumatic Distress *(PDST)*

The respondent's subjective response to the index trauma described above is evaluated on the DAPS at two levels. At the *general level*, his score on the Peritraumatic Distress *(PDST)* scale indicates the degree of negative emotionality and negative thoughts he experienced at the time of, or soon after, the trauma. Various studies indicate that higher levels of peritraumatic distress are associated with greater traumatization and a greater likelihood of developing PTSD or ASD. At the *specific level*, his endorsements of the individual items on the *PDST* scale can be interpreted in terms of the amount of fear, horror, disgust, etc., that he experienced at the time of the trauma as compared to others who have been exposed to trauma.

The respondent has a *T* score of 73 on the *PDST* scale, indicating that he experienced more distress during or soon after the index trauma than the average trauma victim. Peritraumatic distress at this level indicates that he was significantly traumatized by what he experienced, and thus he is likely to report significant posttraumatic symptomatology. His endorsements of the specific items on the *PDST* scale are presented below, followed by a graphic profile of his *PDST* item scores (relative to the mean *PDST* item scores for the normative sample).

Distress at (or around) the time of the Index Trauma	Item response	Raw score
15. Fear	Very much	5
16. Helplessness	Very much	5
17. Horror	Very much	5

18. Guilt	Quite a bit	4
19. Shame or humiliation	Quite a bit	4
20. Disgust	A little	2
21. Upset	Very much	5
22. Thought he might die	None	1



Note. Male-specific norms have been used to generate this profile. The clinical skyline that appears on the profile graph represents the mean item score for each of the *PDST* items obtained for the normative sample. Item responses that are on or above the straight dashed line that appears on the profile graph at an item response level of "4" ("Quite a bit") indicate especially high levels of negative response at the time of, or soon after, the trauma.

Peritraumatic Dissociation *(PDIS)*

Peritraumatic dissociation refers to alterations in awareness, especially those involving depersonalization and derealization, which occur during a traumatic event. Such responses may arise when a sufficiently destabilizing event temporarily overwhelms the individual's nervous system, or may represent the activation of previous dissociative capacities in the face of new emotional distress. Research indicates that individuals who dissociate at the time of a trauma have a greater likelihood of developing ASD or PTSD later on.

The respondent has a *T* score of 75 on the Peritraumatic Dissociation *(PDIS)* scale, indicating clinically significant levels of peritraumatic dissociation at the time of the index trauma.

This response may be associated with significant posttraumatic stress as reported by the respondent (see the following section on the Posttraumatic Stress Scales).

His item responses on the individual items of the *PDIS* scale are presented in the following table.

Dissociation at (or around) the time of the trauma	[illegible] response	Raw score
23. His mind went blank.	Some	3
24. He "spaced out".	Some	3
25. Things around him felt unreal or strange.	Very much	5
26. His body felt strange or seemed to change size or shape.	Not at all	1

27. Time seemed to slow down or speed up.	Very much	5
28. He wasn't completely aware of what was going on around him.	Some	3

Posttraumatic Stress Scales

The posttraumatic stress scales of the DAPS evaluate (a) the extent to which the respondent is experiencing each of the three clusters of symptoms common to PTSD and ASD (i.e., intrusive reexperiencing, avoidance/numbing, and autonomic hyperarousal), (b) the overall severity of his posstraumatic stress symptoms, and (c) the impact these symptoms may be having on his overall psychosocial functioning.

Reexperiencing *(RE)*

The *RE* scale assesses the reexperiencing symptom cluster of PTSD and ASD. This cluster generally involves intrusive thoughts about the trauma, flashbacks, upsetting memories, and dreams or nightmares of the traumatic event, as well as psychological distress and autonomic reactivity upon exposure to trauma-reminiscent events. Reexperiencing is often, but not inevitably, triggered by a stimulus in the environment that is in some way similar to aspects of the original trauma. When the intrusive memories are sensory, as occurs in flashbacks, they may consist of auditory, visual, olfactory, tactile, or gustatory sensations associated with the original event. These intrusive sensations and memories are often experienced as ego-dystonic and quite upsetting, and may trigger a sense of reliving the original traumatic event.

The respondent's *T* score on the *RE* scale is 130. This suggests that he is undergoing significant posttraumatic stress. He is regularly bothered by intrusive recollections of the traumatic event and may feel unable to control these reexperiencing symptoms. An elevated score at this level on the *RE* scale is often accompanied by attempts to avoid environmental events that might trigger more reexperiencing.

Reexperiencing scale items	Item response	Raw score
30. Upsetting thoughts or memories of the experience popped into your mind.	4 or more times a week	5
34. Getting upset or nervous when something or someone reminded you of what happened.	4 or more times a week	5
38. Thoughts or images of what happened that you couldn't get out of your mind.	4 or more times a week	5
42. Feeling frightened or upset when something reminded you of the experience.	4 or more times a week	5
46. Memories of the experience that seemed to come out of nowhere.	4 or more times a week	5
50. A memory of the experience that was so strong or intense that you felt like it was happening all over again.	4 or more times a week	5
54. Having upsetting dreams or nightmares about the experience.	4 or more times a week	5
58. When you thought about the experience, or were reminded of it, your heart started pounding, you broke out in a sweat, or it was hard to breathe.	4 or more times a week	5
62. Feeling like the experience was happening again even though it wasn't.	4 or more times a week	5
66. When something reminded you of the experience, or	4 or more times a week	5

you thought about it, you felt dizzy or you had other reactions in your body.		

Avoidance *(AV)*

The *AV* scale consists of those avoidance responses subsumed under Criterion C symptoms of PTSD and, to some extent, Criterion B and D symptoms of ASD, as described in the *DSM-IV-TR*. These responses include not only conscious attempts to avoid people, places, conversations, and situations that might trigger flashbacks or other intrusive reexperiencing symptoms, but also emotional numbing and constriction. Certain *AV* items, such as not wanting to talk about the traumatic experience and avoiding environmental stimuli that might trigger traumatic memories, represent what is sometimes referred to as *effortful* avoidance. Other *AV* items, such as loss of interest in activities and feeling disconnected from others, tap emotional constriction and numbing, which is thought to be a functionally independent component of PTSD, although it is currently subsumed under the avoidance cluster of symptoms. This second group of symptoms is sometimes known as the *numbing* cluster and often it is more associated with posttraumatic hyperarousal than with effortful avoidance. This report includes scores, and their interpretation, for two subscales of the *AV* scale — Effortful Avoidance *(AV-E)* and Numbing Avoidance *(AV-N)*. Each of these subscales consists of the four *AV* scale items that are most relevant to that subscale.

The respondent's *T* score on the overall *AV* scale is 75. His *T* score on the Effortful Avoidance *(AV-E)* subscale is 84, whereas his *T* score on the Numbing Avoidance *(AV-N)* subscale is 51.

The respondent's overall *AV* score indicates that he is experiencing significant posttraumatic avoidance symptoms. His *AV* subscale *(AV-E* and *AV-N)* scores suggest a tendency to avoid trauma-specific reminders of the index trauma in the environment, but without the extreme withdrawal, numbing, and/or emotional constriction seen in some cases of posttraumatic stress. The respondent may be reluctant to discuss his symptoms with therapists or others and may have problems with treatment adherence.

Avoidance scale items	Item response	Raw score
31. Not wanting to talk about what happened.	4 or more times a week	5
35. Losing interest in doing things since the experience.	Less than once a week	2
39. Not being able to remember part or all of the experience.	Less than once a week	2
43. Feeling less connected to people than before it happened.	Never	1
47. Not being able to feel your emotions as much since it happened.	Never	1
51. Staying away from people or places that reminded you of what happened.	Never	1
55. Trying not to have any upsetting thoughts or feelings about what happened.	4 or more times a week	5
59. Not being able to feel your feelings as much as you did before the experience.	Never	1
63. Not doing certain things because they reminded you of the experience.	Never	1
67. Since the experience, feeling like you won't have much of a future.	4 or more times a week	5

Hyperarousal *(AR)*

The *AR* scale taps the autonomic hyperarousal cluster of PTSD and ASD symptoms. These symptoms are thought to arise from the fact that exposure to overwhelming trauma can prompt sustained hyperactivation of the sympathetic ("fight or flight") component of the autonomic nervous system. Symptoms of posttraumatic autonomic hyperarousal include heightened startle responses, tension, sleeping difficulties, irritability, problems with attention and concentration, and hypervigilance.

The respondent's *T* score on the *AR* scale is 103, suggesting that he is experiencing some combination of tension, irritability, and a tendency to be jumpy or "on edge." He also may complain of various somatic concerns (e.g., muscle tension, gastrointestinal distress) that reflect the effects of sustained hyperarousal. Because hyperarousal symptoms can be quite aversive, some people with an elevated score on the *AR* scale may use drugs, alcohol, or other sedating or soothing devices to down-regulate their emotional state. In order to evaluate this tendency, refer to the Substance Abuse section of this report.

Hyperarousal scale items	Item response	Raw score
32. Problems concentrating or paying attention since it happened.	4 or more times a week	5
36. Since it happened, your mind wandering even though you needed to concentrate.	4 or more times a week	5
40. People irritating you more than they did before the experience.	Less than once a week	2
44. Since the experience, flinching when there was a loud noise or something moved close to your face or body.	2 or 3 times a week	4
48. More trouble falling asleep or staying asleep than you did before it happened.	4 or more times a week	5
52. Feeling more restless since it happened.	4 or more times a week	5
56. Feeling jumpy or on edge since it happened.	4 or more times a week	5
60. Since the experience, having times when you were so alert that you couldn't relax.	4 or more times a week	5
64. Looking out for danger since it happened.	2 or 3 times a week	4
68. Since it happened, being startled or frightened by sudden noises or movements.	About once a week	3

Posttraumatic Stress - Total *(PTS-T)*

The *PTS-T* scale is the sum of the *RE, AV,* and *AR* scale scores and reflects the overall severity of posttraumatic stress symptoms endorsed by the respondent. Typically, a *PTS-T* score in the moderate to severe range (i.e., $T \geq 65$) indicates clinically significant posttraumatic stress symptomatology. However, in some instances, one or two Posttraumatic Stress scales will be elevated at a level that suggests clinical disturbance, yet the total *PTS-T* score will be lower than 65. In such instances, it may be appropriate to interpret the elevated scale score(s) as clinically significant, but to consider the overall level of symptom severity to be insufficient for a PTSD diagnosis.

Based on the respondent's *T* score of 106 on the *PTS-T* scale, the overall severity of his posttraumatic stress symptoms is in the **severe** range.

Posttraumatic Impairment *(IMP)*

The *IMP* scale assesses the respondent's self-reported level of psychosocial impairment as a result of the effects of the index trauma. An elevated score on this scale is also required for a *DSM-IV-TR* diagnosis of PTSD or ASD. *IMP* scale items involve having trouble at work, school, social situations, relationships, or other aspects of one's life. As a result, scores on this scale can be used as an indication of the overall functional impairment associated with his posttraumatic symptomatology. However, the clinician should keep in mind that this is the respondent's subjective estimate of his dysfunction.

The respondent's *T* score on the *IMP* scale is 105, indicating that he reports that the effects of the index trauma are significant, to the extent that his ability to function on an ongoing basis has been compromised. The respondent's scores on the individual items of the *IMP* scale are presented in the following table.

Posttraumatic Impairment scale items	Item response	Raw score
37. Because of what happened to you, not being able to do things as well as you used to.	4 or more times a week	5
45. Problems in your relationships with others because of what happened to you.	About once a week	3
53. Having trouble at work, school, or in social situations because of what happened to you.	4 or more times a week	5
61. Not being able to do things you needed to do because of the stress of what happened to you.	4 or more times a week	5
65. More problems in your life since it happened.	4 or more times a week	5

Note. Only items 45, 53, and 61 specifically address *DSM-IV-TR* criteria for impairment in social, occupational, and other important areas of functioning.

Diagnosis

To meet criteria for a *DSM-IV-TR* diagnosis of Acute Stress Disorder or Posttraumatic Stress Disorder, the respondent must report (a) a Criterion A-level trauma; (b) peritraumatic distress that involves significant fear, helplessness, or horror; (c) significant levels of reexperiencing, avoidance, and hyperarousal; and (d) significant psychosocial impairment. In the case of Acute Stress Disorder, there must be significant peritraumatic dissociation present as well. For a diagnosis of PTSD, the trauma must have been experienced prior to the last month, whereas, for ASD, the trauma must have occurred within the last month. As noted in the DAPS Professional Manual, the scoring procedure for the DAPS has good predictive validity for PTSD relative to other psychological tests. In a validation study of the DAPS, it detected PTSD 88% of the time when it was actually present and did not detect PTSD 86% of the time when it was not present.

The respondent's index trauma occurred more than a month ago. As a result, the diagnostic issue is whether or not Posttraumatic Stress Disorder is present. The relevant diagnostic output is presented in the following table.

DSM-IV-TR criterion	DAPS Decision Rule for PTSD	Criterion met?
A1	Endorsement of at least one trauma exposure involving actual or threatened death or serious injury, or threat to physical integrity of self or others (Items 1-12)	Yes
A2	Experienced intense fear, helplessness, or horror (Item 15, 16, or 17 endorsed as > 2)	Yes
B	Persistent reexperiencing *(RE* raw scale score ≥ 15)	Yes

C	Marked avoidance of stimuli that arouse recollections of the trauma *(AV* raw scale score ≥ 20)	Yes
D	Marked symptoms of anxiety or increased arousal *(AR* raw scale score ≥ 15)	Yes
E	Onset of exposure occurred more than 1 month ago (Item 29 endorsed as > 2)	Yes
F	Clinically significant distress or impairment in social, occupational, or other important areas of functioning (Items 45, 53, or 61 endorsed as > 2)	Yes

Based on the respondent's DAPS responses, he is likely to satisfy diagnostic criteria for Posttraumatic Stress Disorder (PTSD).

As noted earlier, his overall posttraumatic stress level is in the severe range.

This diagnostic output is based on psychological test data, and thus should be followed up with a face-to-face, *DSM-IV-TR* based, clinical interview to ensure the accuracy of this estimation.

Associated Features Scales

The Associated Features scales of the DAPS evaluate three important psychological issues that are often comorbid with posttraumatic stress: posttraumatic dissociation, substance abuse, and suicidality.

Trauma-Specific Dissociation *(T-DIS)*

The *T-DIS* scale evaluates derealization, depersonalization, and detachment symptoms that can persist following exposure to a traumatic event. *T-DIS* scale items specifically tap the posttraumatic dissociative criteria for ASD and the associated features of PTSD. Items include going around in a daze since the index trauma occurred, feeling that things have become unreal since the event, and posttraumatic feelings of being separated from one's body. Posttraumatic dissociation is phenomenologically different from general dissociative symptomatology in that it represents lasting responses to a specific trauma, as opposed to a general tendency to dissociate. Nevertheless, individuals with ongoing dissociative symptoms are more likely than others to dissociate in response to an acute trauma.

The respondent's *T* score on the *T-DIS* scale is 104, indicating that he has developed clinically significant levels of dissociation following the index trauma that remain present at the time of assessment.

Trauma-Specific Dissociation scale items	Item response	Raw score
33. Since the experience, feeling like you were walking around in a dream or a movie.	4 or more times a week	5
41. Since it happened, things not feeling completely real.	4 or more times a week	5
49. Going around in a daze since the experience, not noticing things.	About once a week	3
57. Since it happened, times when you felt separated from your body.	Never	1

Substance Abuse *(SUB)*

The *SUB* scale measures the respondent's self-reported use of drugs and alcohol, a known associated feature of PTSD. Individuals with high *SUB* scores may have serious drug or alcohol

problems that either predate or follow their trauma exposure. Major substance abuse in a trauma survivor can result in treatment disruption, delayed recovery due to impaired processing of traumatic memories, and the possibility of additional traumas in the future.

The respondent's *T* score on the *SUB* scale is 46, indicating that he did not endorse significant substance abuse activities. The *SUB* scale items and the respondent's raw score on each item are presented in the following table.

SUB scale items	Item response	Raw score
70. Having more than three alcoholic drinks a day.	Never	1
73. Using PCP, LSD, or other hallucinogens.	Never	1
76. Using heroin or cocaine.	Never	1
79. Feeling like your use of drugs is starting to control your life.	Never	1
83. Using "uppers" (stimulants) or "downers" (depressants) to get high.	Never	1
87. Using marijuana or hashish.	Never	1
91. Worrying that you might have a drinking problem.	Never	1
94. Not being able to remember things you had done when you were drinking.	Never	1
97. Getting into trouble because of your drinking.	Never	1
101. Someone saying you drink too much.	Never	1

Suicidality *(SUI)*

The *SUI* scale measures the respondent's self-reported suicidal motives, ideations, and behaviors. According to *DSM-IV-TR*, suicidality is a well-established associated feature of PTSD, perhaps especially for those who have experienced major losses or who are suffering extreme psychological pain. Suicidal thoughts and behaviors also are frequently associated with depression, which, in turn, is relatively common among individuals with PTSD. An elevation on the *SUI* scale should always be followed up with a detailed suicide-risk interview.

The respondent's *T* score on the *SUI* scale is 130, indicating that he is reporting significant suicidality. **An interview to assess his level of suicide risk is strongly recommended. Also, specific clinical intervention may be indicated.**

His responses to the individual items of the *SUI* scale are presented in the following table.

SUI Scale Items	Item Response	Raw Score
72. Wishing you could die and not have any more problems or pain.	Often	4
74. Suicidal thoughts.	Very often	5
77. Nearly attempting suicide, then stopping because you scared yourself or because it would hurt too much.	Once or twice	2
80. Having fantasies about suicide.	Very often	5
84. Making a plan about how you could commit suicide.	Once or twice	2
88. Thinking about how to kill yourself.	Often	4
92. Threatening to commit suicide.	Once or twice	2
96. Doing something dangerous because you hoped you might be killed (for example,	Once or twice	2

driving much too fast or taking dangerous chances).		
100. Wanting to end your life.	Often	4
104. Attempting suicide.	Never	1

Note. At least one suicidality item has been endorsed by the respondent. Suicidal endorsements require direct assessment, as well as -- if indicated -- specific clinical intervention above and beyond trauma treatment.

Diagnostic Summary

In summary, the respondent appears to satisfy *DSM-IV-TR* diagnostic criteria for PTSD. The severity of this disorder is estimated to be in the severe range. In addition, he reports clinically meaningful levels of trauma-specific dissociation and suicidality. This clinical presentation, especially in the presence of other significant symptomatology, may signal the presence of a more "complex" PTSD. This more complicated clinical picture often requires more extended or intense psychological and/or pharmacological treatment. Furthermore, greater attention to avoidance or subjective distress issues may be indicated during treatment, perhaps especially in the context of therapeutic exposure to traumatic memories.

DAPS Item Response Summary Table

Item#	Response	Item#	Response	Item#	Response	Item#	Response
1	2	27	5	53	5	79	1
2	2	28	3	54	5	80	5
3	1	29	5	55	5	81	4
4	2	30	5	56	5	82	1
5	2	31	5	57	1	83	1
6	2	32	5	58	5	84	2
7	2	33	5	59	1	85	3
8	2	34	5	60	5	86	1
9	2	35	2	61	5	87	1
10	2	36	5	62	5	88	4
11	1	37	5	63	1	89	3
12	2	38	5	64	4	90	1
13	2	39	2	65	5	91	1
14	11	40	2	66	5	92	2
15	5	41	5	67	5	93	4
16	5	42	5	68	3	94	1
17	5	43	1	69	3	95	1
18	4	44	4	70	1	96	2
19	4	45	3	71	1	97	1
20	2	46	5	72	4	98	4
21	5	47	1	73	1	99	1
22	1	48	5	74	5	100	4
23	3	49	3	75	4	101	1
24	3	50	5	76	1	102	4
25	5	51	1	77	2	103	1
26	1	52	5	78	1	104	1

DAPS Item Response Frequency Table

1	2	3	4	5	Missing
30.00%	8.89%	10.00%	13.33%	37.78%	0.00%

Note. Percentages indicate the total proportion of DAPS item responses in the current protocol at each item response level (i.e., 1, 2, 3, 4, and 5) for DAPS items using a 5-point Likert-type response scale (i.e. Items 15 through 104).

End of Report